osborne · margo

Health Law & Policy

Local Health Integration Networks: Structure, Powers and Accountability

Submitted to:

The Change Foundation

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INTRODUCTION

This Report is submitted by Osborne • Margo in response to a request from The Change Foundation for a summary of the powers and accountabilities of Local Health Integration Networks ("LHINs") in Ontario. The Report is intended to assist in an understanding of the structure, powers and accountabilities of the LHINs and outline areas for further discussion and debate, including clarifying the full scope of LHIN powers and notable policy implications with the creation of LHINs.

The Report is not intended to provide a detailed summary of all of the legislation, policies and agreements relating to LHIN powers and accountabilities. Rather, the Report provides an overview of LHIN accountabilities and powers to assist in a general understanding of this area. The Report is not a legal document and does not constitute legal advice. Assistance regarding the interpretation of legislation and applicable agreements regarding the accountabilities and powers of LHINs is not contained in this Report and should be sought from legal counsel if required.

The Report includes a summary of the following information about LHINs:

1. LHIN corporate structure, status and relationship to the Ministry of Health and Long-Term Care of Ontario;

2. LHIN powers, permissible acts, limitations of these powers and any notable policy shifts in health-care regulation with the creation of LHINs;

3. Areas of potential uncertainty or ambiguity relating to the scope of LHIN powers and accountabilities in the relevant legislation (i.e., *Local Health System Integration Act, 2006* and *Commitment to Future of Medicare Act, 2004*) and the accountability agreements;

4. A summary of the terms of the accountability agreement between the Ministry and LHINs, with a focus on LHIN powers, relevant processes and powers and oversight retained by the Ministry;

5. A summary of the terms of the Hospital Service Accountability Agreement template between LHINs and hospitals, with a focus on LHIN powers and relevant processes, and significant changes from the previous Hospital Accountability Agreement template; and

6. Commentary on any significant differences in LHIN powers compared with other provincial regional health system governance structures.

WHAT ARE LHINs?

LHINs are non-share capital, (not-for-profit) statutory corporations, designated as Crown agencies. They were created by the Ontario government in April 2005 as part of a government health-care management reform. They are governed by the *Local Health System Integration Act, 2006* which was passed in March 2006 (the "LHSIA") and are funded by the Ministry of Health and Long-Term Care ("Ministry").

LHINs in a Nutshell

- **14 LHINs, each with its own geographical region.**
- **Not-for-profit crown corporations, with staff, a CEO and governed by a board of directors.**
- **Mandate is to plan, fund and integrate health-care services in their local area.**
- **Do not directly provide health-care.**
- **Required to consult with the local community about health-care planning and integration.**
- **Accountable to the Minister of Health and Long-Term Care through a written accountability agreement.**
- **Must have service accountability agreements with health service providers that receive LHIN funding.**
- **Do not fund or have powers in regard to physicians or independent health practitioners.**

Mandate

The mandate of the LHINs is to plan, fund and integrate local health-care services. As of April 1, 2007, LHINs assumed their full role of planning and funding health services when the Ministry formally transferred the requisite funding for the health service providers governed by LHINs to the LHINs. LHINs cannot directly provide health-care services without the approval of the Lieutenant Governor in Council.

A main premise for the creation of LHINs is that community-based care is best planned, coordinated and funded in an integrated manner at the community level, because local people are best able to determine their health service needs and priorities. Accordingly, LHINs are required to engage in community consultation on an ongoing basis, and develop plans and set priorities for the delivery of health services in its region. The "community" is defined in LHSIA as including patients, health service providers and employees involved in the local health system.

LHIN Geography

There are 14 LHINs in Ontario, delineated by geographic boundaries/regions (see Appendix A). The 14 LHIN geographic boundaries were created to reflect local areas where people naturally seek health-care (based on evidence-based methodology in collaboration with the Institute for Clinical Evaluative Sciences). The boundaries are permeable for patient care, meaning people can continue to choose their health-care provider and are not required to seek health-care from providers only located within their LHIN. All 14 LHINs contain at least one high-volume hospital. Further information on the LHINs can be obtained from www.lhins.on.ca

LHIN Jurisdiction

LHINs are responsible for the planning, integration and funding of their local health services for the following entities:

- Public and Private Hospitals
- Psychiatric Facilities (with exceptions)
- Community Care Access Centres (CCACs)
- Community Support Services
- Long-Term Care Facilities
- Community Mental Health and Addictions Services
- Community Health Centres

These entities are accountable to and subject to the power of LHINs. LHSIA refers to these entities as "health service providers" ("HSPs")[*]. Notably, physicians and independent health practitioners are not HSPs. LHINs do not have powers relating to physicians, nor will they directly fund physician services.

[*] This Report focuses on those health-care providers that are subject to LHIN authority and they are referred to throughout this Report as "HSPs" or "providers".

LHINs now oversee approximately one-half of the $40 billion health-care budget in Ontario. LHINs must enter into service accountability agreements with providers regarding the terms and conditions on funding (See page 26 for further details).

Organizational Structure and Governance

Each LHIN has a Chief Executive Officer ("CEO") and a Board of Directors, comprised of no more than nine appointed members (by Order-in-Council). Each LHIN is required to have a community Nominations Committee to identify and recommend potential appointees to the Board. The Board of Directors is responsible for the management and control of the affairs of the LHIN and is the key point of interaction with the Ministry. The CEO reports to the Board of Directors.

Directors can be appointed for up to three-year terms, with renewal for an additional three-year term. They are compensated at rates determined by the Lieutenant Governor in Council.

Board meetings are open to the public. In the limited circumstances as defined in LHSIA, a Board may hold a closed session within a public meeting (e.g., for human resources advice and information from legal counsel).

LHINs are accountable to the government through an accountability agreement with the Minister of Health and Long-Term Care (See page 20 for a summary). The accountability agreements are available on the LHIN websites.

Initial LHIN Planning Deliverables

Integration Priority Reports

Prior to the creation of LHINs, and through facilitation provided by the Ministry, integration priority reports for each of the 14 geographic areas in which a LHIN would be established were submitted by the end of February 2005 to assist in LHIN planning and integration opportunities. The reports were the result of 14 LHIN community workshops held across Ontario by the Ministry in November and December 2004. Approximately 4,000 people attended the workshops. At each workshop, participants identified integration priorities important for their geographic area and voted at the end of the day for the top 10 integration priorities in patient care and

administrative/support services. A report was developed for each geographic area using the top 10 priorities identified by the participants for that area.

Integrated Health Service Plan

Each LHIN is required to develop a publicly available integrated health service plan for its region. After active community consultations throughout 2005 and 2006, LHINs provided their first Integrated Health Services Plans in the fall of 2006, setting out their vision, priorities and strategic directions for their local health system. Each Plan is to be consistent with the Ministry's provincial strategic plan, the funding received by the LHIN from the Minister and any other terms prescribed by the governing legislation. The Integrated Health Service Plans are available on each LHIN's website.

LHIN Committees/Support Initiatives

Health Professionals Advisory Committee

Each LHIN has established a Health Professionals Advisory Committee ("HPAC"), as required under the LHSIA. Each HPAC has up to fifteen members representing a variety of the health professions regulatory colleges (e.g., College of Physicians and Surgeons of Ontario, College of Nurses of Ontario, College of Psychologists of Ontario, etc.).

HPACs are responsible for assisting the LHIN by providing advice on how to achieve patient-centered health-care. Among the variety of areas of interest, the Committees will specifically consider the following:

- Health status of demographic segments of the population as specified by the LHIN
- Innovative approaches to health service delivery
- Utilization of health human resources
- Health promotion and wellness
- Other matters the Committee determines and that are consistent with the objectives of the LHIN

- Other areas the LHIN considers appropriate and specifies to the Committee

LHIN Shared Services Organization (LSSO)

The LSSO is a division of the Toronto Central LHIN. It was established by the LHINs as a common service group to support operational cost effectiveness, efficiency and consistency of the LHINs. It coordinates shared functions such as human resources and audit. Legal services are provided by the Ministry of the Attorney General.

Critical Care Strategy

In May 2006, each LHIN appointed a Critical Care Leader to support the delivery planning and coordination of critical care. These leaders are responsible for leading critical care planning, rehearsal and event management across LHINs, and supporting critical care performance measurement and improvement across LHINs.

Aboriginal and First Nations, French Language Planning

The LHINs are required to establish Aboriginal and First Nations and French Language planning entities. These entities are required to act in an advisory capacity to the LHINs for health service planning.

LHIN Reviews

Effectiveness Review

An Effectiveness Review of LHINs, relating to the effectiveness of carrying out the transfer and devolution of authority contemplated in the Ministry-LHIN Accountability Agreements, is being conducted by external consultants KPMG and is expected to be completed by Fall 2008. The Effectiveness Review is intended to move the transformation of Ontario's health system forward.

LHSIA Review

A committee of the Legislative Assembly will begin a review of LHSIA and its accompanying regulations between March 2009 and March 2010. It will make recommendations to the Assembly regarding possible amendments to LHSIA and its regulations.

LHIN POWERS AND RESPONSIBILITIES

The principal powers and responsibilities of LHINs are summarized as follows with further explanation on the scope of these powers and responsibilities immediately below.

Planning and Community Engagement

- **Required on an ongoing basis under Part IV of LHSIA, and for certain types of integration decisions under Part V.**

Funding of Health Service Providers

- **As of April 1, 2007, LHINs directly fund HSPs**
- **LHINs are governed by and manage their HSPs under the LHIN Financial Management framework (i.e., Schedule 5 of the Ministry-LHIN Accountability Agreement)**
- **Funding powers come with the ability to require HSPs to undergo audits and provide financial statements or other information required by LHINs**

Integration of Services and Programs

- **LHINs can issue Integration Decisions to HSPs to:**
  1. **Stop, start, merge, adjust or transfer services;**
  2. **Permit voluntary integration by HSP(s) (unlike #1, this Integration Decision could involve a merger or amalgamation of HSPs or other health-care providers, or closure of HSP(s) if it is voluntarily agreed to by the HSPs and not opposed to by the LHIN); and**
  3. **Stop a voluntary integration of services or programs.**
- **A LHIN may also integrate the local system by changing funding to HSP(s).**
- **The Minister retains certain integration powers that have not been devolved to LHINs which may be exercised by issuing an Integration Order (e.g., to require a HSP to amalgamate with another HSP, cease operating or wind up operations, or transfer all its operations to another entity).**

Service Accountability Agreements (SAAs)

- **LHINs must enter into SAAs with all HSPs over 3 years.**
- **SAAs establish accountability for LHIN funds to HSPs, service standards and targets, protocols for monitoring and reporting and progressive performance management.**
- **Explicit balanced budget required for all HSPs.**
- **LHINs can use certain powers they have under the Commitment to the Future of Medicare Act to achieve HSP compliance with the terms of the SAA (e.g., compliance directives/orders).**
- **SAAs between LHINs and HSPs must be made available to the public by both the LHIN and the HSP.**

Planning and Community Engagement

LHINs are required to engage in community consultation on an ongoing basis, develop plans (e.g., Integrated Health Service Plans) and set priorities for the delivery of health-care services in its region. Under LHSIA, the term "community" includes patients, health service providers and employees involved in the local health system. The scope of community consultation is not prescribed under LHSIA, but can include holding community meetings, focus groups or establishing advisory committees (i.e., see sub-section 16(3) of LHSIA). In turn, HSPs are required under LHSIA to engage its local community when it develops plans and sets priorities for the delivery of its health services (i.e., see sub-section 16(6) of LHSIA).

Accordingly, LHINs have broad responsibilities to consult with the stakeholders in its local health-care system. As outlined below, LHIN planning and community engagement responsibilities are directly linked to their powers to integrate health-care services and programs in their regions.

Funding

As previously noted, LHINs assumed direct funding responsibility and allocation for the health service providers it governs, as of April 1, 2007. LHINs will also monitor fiscal performance by providers and can direct HSPs to undergo both financial and operational audits. Ancillary powers are provided to enable the LHINs to be accountable for the funding they provide. These include the ability to require HSPs to provide financial statements or other information required by LHINs (even from non-HSPs such as hospital foundations if the Lieutenant Governor in Council issues an authorizing regulation).

The Ministry established a new Financial Management Branch (FMB) to support the LHINs' fulfillment of their funding and allocation mandate. LHINs will instruct the Ministry to make or adjust payments to each provider throughout the fiscal year. On behalf of LHINs, the FMB will also conduct annual reconciliation of funding to provide and produce financial reports for the LHINs.

Integration of Local Health Services and Programs

Integration of health services and programs is at the core of the LHIN mandate and accordingly the LHINs are provided with various powers and responsibilities to achieve integration.

The LHIN may integrate its local health system in four ways:

(i) Through use of the LHIN funding powers (e.g., the coordination of services, reductions in funding to a service);

(ii) The facilitation and negotiation of integration of entities or services involving an HSP;

(iii) Issuing an integration decision requiring an HSP to undertake certain kinds of integration relating to services the LHIN funds or proposes to fund; and

(iv) Issuing an integration decision ordering the HSP not to proceed with all or part of an integration proposed by the HSP if the integration relates to services funded by the LHIN.

A LHIN cannot require an HSP to close or amalgamate, nor can it direct an HSP to change the composition or the structure of its board of directors or membership. The LHIN authority to integrate entities or services applies to all HSPs, irrespective of whether the HSP is a denominational or religious organization; however, LHINs may not issue integration decisions that unjustifiably (as determined under section 1 of the *Canadian Charter of Rights and Freedoms*) require a religious organization to provide a service contrary to the religion related to the organization.

The Ministry retains certain integration powers for the local health system and province through issuing an "integration order" (further summarized on page 14).

Under LHSIA, to "integrate" or "integration" refers to the coordination of health-care services by a variety of means, including:

- partnering agreements
- transferring or closing services

- providing services at a certain level, quantity or extent
- merging services

"Service" is broadly defined under LHSIA such that it can include all services or programs provided by HSPs.

LHSIA contains provisions to address issues that may arise from integration, for example issues relating to privacy, the transfer of property, and the applicability of labour legislation and labour law.

Integration Decisions

A LHIN is not required to issue an integration decision when it integrates through its funding powers. However, a LHIN must issue an integration decision in the following three circumstances:

(i) when it facilities or negotiates integration involving a HSP;

(ii) when it requires an HSP to undertake integration; and

(iii) when it orders an HSP not to proceed with integration.

An integration decision can require the provider to provide, cease or adjust a service, or to transfer all or part of a service from one location to another. LHSIA provides certain preconditions to the issuance of an integration decision which include:

(i) the requirement that the LHIN has posted its IHSP publicly;

(ii) the LHIN considers it in the public interest to issue the integration decision ("public interest" is not defined in LHSIA); and

(iii) the decision relates to an HSP for services the LHIN funds or proposes to fund.

In addition, an integration decision cannot be contrary to the terms of the LHIN's Accountability Agreement with the Ministry.

An integration decision must outline:

(i) the purpose and nature of the integration;

(ii) the parties to the integration decision;

(iii) any integration activities required; and

(iv) the timeframes involved in the proposed integration.

Integration decisions cannot be implemented by LHINs until 30 days prior notice of the intention to issue a decision has been provided to the HSP and the decision is available to the public, providing the opportunity for written submissions. The final LHIN integration decision may be different from the proposed decision that was provided in the notice to the HSP and the public. Within thirty days of the LHIN's public posting of a proposed decision, any person (e.g., an HSP, public member, stakeholder, etc.) may make written submissions to the LHIN on the proposed decision. The LHIN may not act on the proposed decision until this process is completed.

The parties to the integration decision are required to develop a human resources adjustment plan relating to the implementation of the integration decision.

Finally, an integration decision cannot unjustifiably, as determined under the *Canadian Charter of Rights and Freedoms,* require a religious organization (e.g., a denomination hospital) to provide a service that is contrary to the religion of the organization.

Ministry Integration Orders

A LHIN cannot close a HSP's operations, or require it to amalgamate with another entity. This power remains with the Ministry. If the Ministry considers it in the public interest, the Minister may issue an "*integration order*" which can require the provider to cease operations, amalgamate with another provider or transfer all of its operations. In addition, an integration order by the Ministry cannot relate to services for which the LHIN does not provide funding or propose to fund.

Before issuing an integration order, the Minister must receive the advice of the LHIN involved about the proposed integration. The Minister must provide notice to the HSP and an opportunity to make written submissions. As in the case of LHIN integration decisions, the Minister cannot unjustifiably require a religious organization to provide a service that is contrary to the religion of the organization.

Finally, orders by the Minister cannot require a HSP to transfer charitable property to a person or entity that is not a charity. Similarly, a non-charitable service provider cannot be ordered to hold property for a charitable purpose and to receive property from a person/entity that is not a charity.

Integration Initiated by the Health Service Provider

HSPs can initiate the integration of services funded by the LHIN with another entity (including amalgamation and transfer of services), providing the health-care organization complies with the requirements under LHSIA by providing the LHIN with notice of its proposed integration and awaiting LHIN feedback, if any, on the proposed integration. Voluntary integration could even extend to mergers, amalgamations and the winding-up of HSPs. The LHIN may issue an integration decision requiring the HSP not to proceed with the integration. Prior to doing so, LHSIA requires the LHIN to provide a draft copy of its decision to the parties to the integration and to the public for comment (and as outlined under the "Integration Decision" section, the LHIN is required to follow a consultation process before issuing the final decision).

Mandatory Compliance: Integration Decisions/Orders

It is mandatory for a HSP to comply with the final LHIN Integration Decision or Ministry Integration Order. The LHIN or the Minister may apply to the Superior Court of Justice (Ontario) for an order directing a party to comply with the decision or order.

Service Accountability Agreements

LHINs are required to enter into Service Accountability Agreements ("SAAs") with all the health-care providers subject to its authority. LHIN obligations and powers with respect to SAAs are governed by both LHSIA and the *Commitment to the Future of Medicare Act* ("CFMA").

The purpose of SAAs is to establish accountability for the use of the public funds provided by LHINs, service standards and targets that providers are expected to meet, protocols for monitoring and reporting, as well as possible interventions by LHINs if and when improvement is deemed necessary. It is expected that most and over time, all SAAs will require providers to deliver programs and services on budget.

The accountability agreements between the Minister and the LHINs, and the terms under LHSIA require LHINs to enter into SAAs with hospitals, to take effect April 1, 2008 (See page 26 for further information on these agreements). SAAs are also to be negotiated by LHINs with HSPs in the remaining sectors and the schedule provided for negotiating SAAs is as follows:

- Community Health Centres – March 31, 2009
- Mental Health and Addiction Agencies – March 31, 2009
- Community Support Service Agencies – March 31, 2009
- Community Care Access Centres – March 31, 2009
- Long-Term Care Homes – March 31, 2010

In the event that after ninety days of LHIN negotiations with service providers a mutually satisfactory SAA is not executed, LHINs may use the process set out in the CFMA, to impose an SAA on an HSP and the Ontario courts can enforce the order. The CFMA sets out the process LHINs must follow in the notice and imposition of an SAA. The process provides for discussions between the LHIN and service provider, but ultimately the LHIN can impose the SAA through a "Compliance Directive" and "Order". If a service provider fails to comply with the Order, it may be subject to penalties.

Until the LHINs negotiate and enter into SAAs with health service providers, the existing agreements remain in force (as transferred or assigned to LHINs by the Ministry).

The terms of the CFMA require the Minister and LHINs to make copies of SAAs either party has entered into available to the public at the offices of the Ministry or the LHIN as the case may be (see section 31(3.1) of the CFMA). Similarly, an HSP must post in a conspicuous public place at its site and on its publicly available website, a copy of its SAA with the LHIN (see section 31 (3.2) of the CFMA).

LIMITS ON LHIN AUTHORITY

There are a number of powers that have not been provided to LHINs or which cannot be exercised by LHINs until certain preconditions are met. For example, the LHINs do not have authority to:

- Directly provide health-care services
- Direct amalgamations of HSPs
- Direct changes to provider boards (e.g., changing the composition or structure of the board/corporate membership)
- Order the closure of a hospital/health-care service provider, or direct service providers to close or cease their operations
- Incur a deficit
- Manage or govern physicians and independent health-care practitioners or their services
- Require an HSP to transfer property that belongs to a charity to a provider or organization that is not a charity

Further, LHINs can only carry out certain actions if "preconditions" or approvals are first obtained. For example:

- Borrowing money, only with the prior approval of the Lieutenant Governor in Council
- Receiving money (other than from the Crown), only upon the prior approval of the Minister of Finance and the Minister of Health and Long-Term Care
- Participating in fundraising, only upon prior consent from the Minister of Health and Long-Term Care, or in some cases the Minister of Finance
- Directly making orders affecting hospital CEO compensation (although the LHIN may make a recommendation to the Minister that such an order be made and the Minister may then recommend to the Lieutenant Governor in Council that such an order be made under subsections 28(5) and (6) of the *Commitment to the Future of Medicare Act, 2004*)

MINISTRY RESPONSIBILITIES

With the creation of LHINs, the Ministry has described its changed role as primarily focusing on providing stewardship to the system. Its stated responsibilities remain the provision of high quality, accessible health-care services that meet the needs of Ontarians.

In practical terms, the Ministry will provide the following main functions:

- *Development of a Provincial Strategic Plan*: establishing overall strategic directions and provincial priorities for the health system (including the principles, goals and baseline requirements for all LHINs);
- *Developing legislation, regulations, standards, policies and directives* to support strategic directions within the context of its overall stewardship role;
- *Providing compliance and licensing services* (e.g., Long-Term Care Homes);
- *Monitoring and reporting* at a provincial level on the performance of the health system and the health of Ontarians;
- *Providing health information, funding and financial management policies and tools* which enable LHINs to make evidence-based decisions;
- *Establishing an Aboriginal and First Nations Health Council and a French Language Health Service Advisory Council*, both to act in an advisory capacity;
- *Establishing funding models* and funding levels for the health system; and
- *Funding major capital projects*.

In addition, with respect to the LHIN mandate, as previously noted, the Ministry retains significant powers to independently control and mandate the amalgamation of health service providers, their closure and transfer of operations.

Ministry Managed Programs

The Ministry has retained responsibility for certain programs and health-care providers (i.e., these programs and providers are not subject to LHIN management or LHSIA):

- Public Health
- Physicians and individual practitioners
- Ambulance services
- Provincial networks and programs (e.g., Provincial drug programs, and Cancer Care Ontario funded cancer programs)
- Midwifery and Chronic Disease Programs
- Family Health Teams
- Homemaking and Nursing Services (under the *Homemaking and Nursing Services Act*)
- Direct Funding-Self Managed Attendant Services
- Laboratories
- Independent Health Facilities
- Supportive Housing (dedicated portfolio and rent supplements)
- Inter-ministerial Provincial Advisory Committee (IMPAC)
- Homes for Special Care Program
- Acquired Brain Injury (ABI)-Individualized Funding
- Elderly Persons Centres
- Palliative Education
- Personal Support Worker Training

Further, the Ministry will continue to process payments and determine policy for:

- High Intensity Needs Fund and Lab Costs
- Pay Equity Program
- Structural Compliance Program
- Rate Reduction Program
- Municipal tax Allowance
- High Wage Transition Fund
- Occupancy-Based Funding
- Exceptional Circumstance Funding

MINISTRY AND LHIN RELATIONSHIP

The relationship of the LHINs with the Ministry is primarily governed by a Memorandum of Understanding and an Accountability Agreement with each LHIN ("MLAA"). The provisions in LHSIA require that the Minister enter into an accountability agreement with each LHIN. MLAAs must be for more than one fiscal year and comply with the content requirements set out in LHSIA. The Minister may impose a MLAA on a LHIN if the Minister and a LHIN are unable to reach agreement through negotiation. Copies of a MLAA must be made available to the public.

The Ministry created the LHIN Liaison Branch, which is responsible for the LHIN/Ministry Accountability Agreements and supporting the LHINs and Ministry in fulfilling their commitments.

The main features of the MLAA are summarized as follows with further explanation on the rights and obligations of the Ministry and LHINs under MLAAs immediately below.

MLAA Main Features

- **Parties are the Ministry and the individual LHIN**
- **Current MLAA applies to 3 fiscal years: 2007/08, 2008/09, and 2009/10**
- **Template main agreement (i.e., same for all LHINs) with Schedules that provide individual LHIN performance obligations and indicators**
- **MLAAs include:**
  - **LHIN performance goals and objectives, performance standards, targets and measures and LHIN spending plans**
  - **Health system management, compliance and planning responsibilities of each party**
  - **Planning, integration and community engagement responsibilities**
  - **LHIN balanced budget requirement and annual reporting with audited financial statements to the Ministry**
  - **Ministry retained authority for capital funding (except in limited circumstances)**
  - **Information management and e-Health responsibilities**

Ministry-LHIN Accountability Agreement

The MLAAs include LHIN performance goals and objectives, performance standards, targets and measures, and a plan for spending the money LHINs receive from the Ministry. Each LHIN executed an individual Accountability Agreement with the Minister.

Nature and Structure of the MLAA

The current MLAA covers three fiscal years, from April 1, 2007 to March 31, 2010. The MLAA template is the same for each LHIN. What varies among MLAAs is funding amounts and performance targets for each LHIN. The MLAA is a short primary agreement (4 pages) with eleven schedules. The primary agreement sets general areas of accountability for each party. It also sets out how the parties will manage and improve performance under the MLAA. The eleven schedules to the MLAA are as follows:

1. General
2. Community Engagement, Planning and Integration
3. Local Health System Management
4. Information Management Supports
5. Financial Management
6. Financial Process Protocols
7. Local Health System Compliance Protocols
8. Integrated Reporting
9. Allocations
10. Local Health System Performance
11. e-Health

The General Schedule sets out matters that apply to all schedules, for example definitions and a process for updating the MLAA. It also sets out a primary purpose for the MLAA schedules, which is to support the ongoing devolution of authority from the Ministry to the LHIN for its local health system. The MLAA states that this devolution is to enable the Ministry to become the "steward" of the health-care system, and to enable the LHIN to be accountable for funding, planning and integrating services in its local health system.

Health System Management, Compliance and Planning

Health System Management

The MLAA sets out the health system management and planning responsibilities of the Ministry and the LHIN. As already outlined, the Ministry is responsible for provincial standards that apply to health-care providers. The agreement sets out the programs that the Ministry will continue to manage and fund, including public health, health human resources, ambulances and laboratories (see Schedule 3 of the MLAA).

Consistent with the powers of LHINs outlined in LHSIA, the MLAA provides that a LHIN's general responsibilities include making decisions about the funding, performance requirements and services of HSPs in the local health system. The LHINs also have responsibilities in regard to specific sectors. Examples of these sector-specific responsibilities include the following:

1. Protect funding that the Ministry designates for specific programs, such as convalescent care beds, uninsured person funding within community health centres and specific components of community mental health; and

2. Require health service providers to provide services in accordance with Ministry standards, for example in regard to hospital programs funded through base budgets, certain CCAC programs, and hospital mental health services.

Compliance Protocols

The MLAA also sets out the roles of the Ministry and LHIN in regard to compliance protocols (i.e., see Schedule 7). The Ministry maintains its powers under legislation relating to compliance, inspection and enforcement. These powers include appointing an investigator or supervisor for a health service provider. The Ministry will also make decisions about suspending or closing a health service provider's operations, or revoking a health service provider's licence.

The LHIN does have responsibilities in the MLAA relating to compliance. In managing the local health system, the LHIN will conduct audits and reviews of HSPs. The LHIN must notify the Ministry about non-compliance by HSPs with legislation, SAAs, and other requirements. The LHIN must also notify the Ministry about financial issues and

other matters that affect compliance with long-term care home legislation (however, LHINs will not inspect long-term care homes).

Planning, Integration and Community Engagement

Finally, the MLAA also sets out the Ministry and LHIN obligations in regard to planning, integration and community engagement (i.e., see Schedule 2). The LHIN has several obligations relating to the Integrated Health Service Plan ("IHSP"). These obligations include developing a guide to support the future development of the IHSP and demonstrating progress on the implementation of IHSP priorities. A notable obligation of the LHIN is a requirement to consult with the Ministry before the LHIN issues a decision to integrate, or stop integration, under LHSIA.

Financial Matters

LHIN Balanced Budgets

LHINs are required to achieve a balanced budget for each year of the MLAA (i.e., see Schedule 5). This requirement applies to the budget for a LHIN's corporate operations, and to the budget for the funding of HSPs. The MLAA also requires a LHIN to include annual balanced budget provisions in their SAAs with hospitals and CCACs. A LHIN must also provide multi-year funding targets to each hospital in its local health system and prepare a plan to implement multi-year funding targets for other HSPs. Further, LHINs are required under the MLAA to provide Annual Service Plans for spending the funding received by the LHIN from the Ministry (the ASPs are posted on many LHIN websites).

A LHIN is restricted in the MLAA from reallocating to its operating budget those funds it receives from the Ministry to fund HSPs (i.e., see Schedule 5). Subject to certain conditions, a LHIN may reallocate funding across the local health-care system. Among other things, these conditions require a reallocation to be consistent with the IHSP, preserve funding for certain programs and services, and consider the effect on future financial and performance plans.

Capital Funding

The Ministry retains its general authority to provide capital funding, but the MLAA also sets out the role of LHINs in regard to capital. This role includes advising the Ministry about the capital needs and projects of the local health system (see Schedule 5).

The MLAA also outlines the small number of situations in which a LHIN will provide approvals and funding for capital, or capital-related funding. These situations include funding for hospital renovations of less than $1 million, hospital capital projects that do not include funding from the LHIN or government, and hospital funding for operations after the finish of a capital project.

LHIN Performance and Indicators

The MLAA provides indicators to assess the performance of the local health system (see Schedule 10). The LHIN must achieve targets for many of these indicators and develop improvement plans where it does not meet a target.

The Ministry is responsible for calculating the results for the indicators and to set benchmarks for the indicators. The MLAA contains 10 indicators divided among four categories: access, quality, integration, and sustainability. LHIN performance management is governed by a process outlined in the agreement.

The Ministry and LHIN also have shared obligations with respect to performance management. These include obligations relating to the development of new indicators, targets, and data sets. The Ministry and LHIN will also develop a "dashboard" to monitor local health system performance.

Information Management and e-Health

Information Management

The MLAA also addresses the collection, storage and use of data and information by the parties (i.e., See Schedule 4). The role of the Ministry is to develop data standards and reporting timelines for the provincial health system. The Ministry will also develop a data repository to collect health data to support the health system and the LHINs. Finally, the Ministry will also receive and process information and data from HSPs on behalf of the LHIN.

The role of the LHIN in information management is to ensure HSPs submit data and information according to Ministry timelines. The LHIN will also work with health service providers to improve data quality and reporting.

e-Health

With respect to e-Health responsibilities, the MLAA provides that the Ministry is responsible for setting provincial e-Health priorities and strategic directions. The Ministry will also provide funding for the LHIN to implement e-Health initiatives. In addition, the Ministry will set technical standards relating to e-Health.

In turn, the LHIN is responsible for developing a LHIN e-Health strategy. There must be a LHIN e-Health work plan and governance model to support the strategy. The LHIN must comply with Ministry standards in regard to e-Health, and ensure health service providers also comply with these standards.

Audit and Reports

LHSIA requires LHINs to provide the Minister with annual reports, including audited financial statements. The Auditor General will also have the authority to audit any aspect of the operations of a LHIN.

LHINs must also provide the Ontario Health Quality Council with information about the LHINs that the Council requests.

HOSPITAL SERVICE ACCOUNTABILITY AGREEMENTS

The main features of Hospital Service Accountability Agreements ("H-SAAs") are summarized as follows with further explanation on the rights and obligations of the LHINs and hospitals under H-SAAs immediately below.

H-SAA Main Features

- **Parties are the LHIN and individual Hospital**
- **Applies to 2 fiscal years: 2008/09-2009/10**
- **Template main agreement (i.e., same for all hospitals) with Schedules that provide individual hospital performance obligations for service volumes and indicators**
- **Hospitals are required to achieve balanced budgets (except in specific circumstances identified in the H-SAA) and performance standards for their services**
- **Performance management processes for hospital non-compliance/performance (e.g., development of improvement plans and amendments to the agreement)**
- **Penalties for non-compliance (e.g., financial, performance requirements, required compliance)**
- **Affirms the LHIN statutory authority to mandate hospital action to remedy any non-compliance, performance issues or disputes**

As previously noted, LHINs are required to enter into SAAs with all service providers subject to LHIN authority. LHINs finalized the template Hospital SAA (H-SAA) in consultation with hospital sector organizations and are working on the development of SAA templates for its other service providers.

The H-SAA builds on the previous Hospital Accountability Agreements that hospitals entered into with the Ministry for fiscal years 2005/06-2006/07 and 2007-08. The H-SAA applies to fiscal years 2008/09-2009/10 (the Agreement starts on April 1, 2008 and ends March 31, 2010).

The H-SAA is signed by the individual LHIN CEO and Board Chair, and the Hospital Board Chair and CEO (the Ministry is not a party to the Agreement). The H-SAA must be in accordance with the funding the LHIN receives from the Ministry and the LHIN Accountability Agreement with the Minister. The H-SAAs are subject to the *Local Health System Integration Act, 2006* and the *Commitment to the Future of Medicare Act,*

2004. The H-SAA does not apply to funding or contractual arrangements that the Hospital has with the provincial Crown, Cancer Care Ontario or the federal Crown.

The H-SAA reflects the relationship of the LHIN to the hospital and the requirement that the LHIN provide funding to the Hospital for its services and operations. The Hospital agrees to ensure it achieves a balanced budget and certain performance standards with respect to the services it provides. In the event that the Hospital either anticipates that it cannot achieve a performance standard or fails to do so, the H-SAA provides a collaborative performance management and improvement process for the LHIN and Hospital to work together to assist the Hospital in achieving the performance standard (e.g., through the development of an improvement plan, a LHIN appointed independent team to assist the Hospital, or amendments to the H-SAA).

Non-compliance with the terms of the Agreement or performance standards can result in a range of possible remedies including financial penalties, financial settlement and recovery, implementation of performance improvement plans and statutory remedies. Ultimately, the LHIN has the power under the CFMA to require the Hospital to take mandated action to remedy non-compliance, a performance issue or dispute.

H-SAA Rights and Obligations

The following is a summary of the principal rights and obligations under the H-SAA for hospitals and LHINs and hospitals.

(a) LHINs

Funding

- The amount of funding to be provided by a LHIN to a Hospital is set out in a Schedule to each H-SAA (Schedule C). The LHIN is not responsible for any Hospital commitments or expenditures that exceed the funding provided by the LHIN.

- Adjustments: a LHIN may make in-year, year-end and after-year-end settlement adjustments to the Hospital's funding. The Agreement sets out required processes prior to the implementation of funding increases, reductions and recoveries (e.g., notice of the proposed adjustment, timing, agreement on the terms and conditions for any adjustments).

- Integration decisions and system planning processes can result in funding adjustments/recoveries to the Hospital.
- Hospitals may dispute funding adjustments, but ultimately LHINs retain the authority to implement a funding adjustment/recovery. LHINs are required to act reasonably in implementing a funding recovery and to consider the impact of the recovery on the Hospital's ability to meet its obligations under the H-SAA.
- The LHIN may reduce or recover funding in response to: the incomplete or late submission (without LHIN prior approval) of the Hospital Annual Planning Submission, late submission of quarterly performance reports, or late/incomplete or inaccurate submission of financial and/or clinical data, as required under the H-SAA. The financial penalties that may be assessed at the discretion of the LHIN are capped at the greater of a 0.03% reduction in the Hospital's base funding or $2,000.00 (as provided in the H-SAA).
- Health Infrastructure Renewal Fund: LHINs approve eligible HIRF projects in accordance with Ministry guidelines (although the Ministry continues to be responsible for funding the approved HIRF projects).

Planning

- Commitment to meet the planning obligations for fiscal years 2010/11 and 2011/12 (e.g., publication of the Hospital Annual Planning Submission Guidelines for 2010-12, announcement of multi-year funding allocations by approximately June 30, 2009, execution of the 2010-12 H-SAA by no later than February 28, 2010).
- In the event the LHIN fails to meet its planning obligations under the H-SAA, it can adjust the Hospital's funding to offset any material adverse effect on the Hospital's services resulting from the delay and/or work with the Hospital to develop a plan to assist the Hospital in offsetting any material adverse effect of the delay.

Reporting

- LHINs are required to report on Hospital required planning information and respond to Hospital submissions within the timelines set out in the H-SAA and Schedules A (Planning Obligations) and B (includes the LHIN Reporting Obligations).

(b) HOSPITALS

Funding Conditions

- Commitment to use LHIN funding to: (i) provide clinical services and the operational activities that support those clinical activities; and (ii) meet the performance obligations outlined in the H-SAA.
- Funding cannot be used for major building renovation or construction, or for direct expenses relating to research projects.

Balanced Budgets

- Hospitals must achieve Balanced Budgets (as defined in the H-SAA) for each fiscal year. LHINs have the ability to waive this requirement in limited circumstances (e.g., if the Hospital has the capacity to fund a negative margin or a reasonable deficit is proposed and a Balanced Budget will be achieved within a timeframe acceptable to the LHIN).

Performance

- Commitment to achieve the performance standards for certain indicators and service volumes set out in the Schedules to the H-SAA. Performance standards and obligations relate to the service volumes, indicators and funding as detailed in the Schedules to the H-SAA, along with numerical targets for each performance standard (Appendix B sets out the service volumes and indicators for the H-SAAs).
- The parties may include additional hospital-specific performance obligations over time to support the implementation of their local Integrated Health Service Plan.
- Restrictions on reducing, stopping, starting, expanding, ceasing to provide or transferring services to another hospital or site of the Hospital if it would result in

the Hospital not being able to achieve its performance standards under the H-SAA. The Hospital must inform the LHIN of any such service plans.

E-Health

- Compliance with any e-health standards set by the Ontario Health Informatics Standards Council that are approved for use.

Planning

- Commitment to meet the planning obligations for fiscal years 2010/11 and 2011/12 (e.g., submission of the Hospital Annual Planning Submission for 2010-12 by October 31, 2009 and signing of the 2010-12 H-SAA by no later than February 28, 2010).
- Collaboration with the LHIN in matters that affect health system improvement.

Community Engagement

- Communication with the LHIN on Hospital community consultations for the development of plans and priorities for the Hospital's delivery of health services.

Reporting and Document Retention

- Hospital must provide to the LHIN plans, reports, financial statement that the LHIN requires to carry out its powers and duties (subject to privacy requirements).

Key Differences between the 2007-08 HAA and the 2008-10 H-SAA

As with the previous Hospital Accountability Agreements, the H-SAA sets out the roles and obligations of LHINs and Hospital in relation to planning, funding and reporting on hospital services and performance. Both agreements acknowledge the independent role of hospital boards in governing their operations and try to provide a collaborative, interest-based, graduated approach to performance issue management and improvement before the imposition of LHIN-mandated remedies.

Many of the new sections address the LHINs' desire to move to standardized terms (e.g., modified definitions of performance factors, standards, targets, etc.) and common

formats in SAAs with all HSPs over the next few years; a step designed to promote equitable treatment among sectors and facilitate the administration of the SAAs.

The following are some of the key changes in the H-SAA:

- Recovery of funding by LHINs (in-year, year end and after year end) for assessed financial reductions or through the system planning process or integration decisions that result in a reduction of hospital clinical services.
- Hospitals are to plan for potential recoveries and any interest earned on funding is recoverable or must be used for hospital services.
- Limitations on the hospital's ability to reduce, stop, start, expand, cease to provide or transfer hospital services if this results in the hospital's inability to achieve performance standards under the agreement.
- LHINs approve eligible HIRF projects in accordance with Ministry guidelines (HIRF projects are still Ministry funded).
- Modifications to the performance management and improvement processes, including the potential requirement for the hospital to participate in an operational and/or financial audit.
- Hospital compliance with e-health standards set by the Ontario Health Informatics Standards Council.
- Communication to LHINs of hospital community engagement efforts and activities.
- Addition of hospital insurance and indemnity obligations to the benefit of the LHIN.
- Modifications to hospital reporting obligations to LHINs (e.g., on forecasting a deficit or the inability to meet a volume target) and the dispute resolution process that include the participation of different representatives of the parties in the resolution process.

DIFFERENCES FROM REGIONAL HEALTH AUTHORITIES

Prior to the 1990s, health service delivery in most provinces was split between a hospital care delivery system with local governance and provincially delivered services such as home care, public health and drug programs.

Beginning in the early 1990s, "regionalization" of health-care management and funding was introduced in all provinces, except Ontario. While health-care regionalization in each province has unique features, the rationale and goals underlying regionalization are similar in all jurisdictions.

Regionalization is steeped in the premise that access to publicly funded, high-quality and sustainable health-care can only be achieved through local planning, integration, administration and management. Outside of Ontario, regional health authorities ("RHAs") were created to manage health-care facilities within their regions. Under RHA legislation, RHAs largely have the same mandate as LHINs for the planning, funding, and coordination of health-care services within their region or province. Accordingly, as in Ontario, with the creation of RHAs, provincial governments devolved significant responsibilities to RHAs and health-care providers became accountable to and directly funded by RHAs. However there are significant differences.

With the introduction of its "Made in Ontario" model of regionalization through the creation of LHINs, Ontario was the last province to move to a regionalized health-care system. There are many similarities in structure, powers and responsibilities between LHINs and RHAs, a summary of which is beyond the scope of this report. However, what follows is a summary of some of the significant distinguishing characteristics of LHINs compared to other provincial regionalization models.

LHINs are not Direct Providers of Clinical Services

As already noted, LHINs do not have the power to directly provide health-care services; rather their powers are restricted to the planning, funding, and integration of service delivery. Existing provider organizations continue to directly provide all health-care services.

In contrast, many provincial RHAs are responsible for service delivery. It is unclear whether, in the future, as LHINs evolve, they will be given authority to directly provide health-care services.

Broad Corporate Powers - Closure of Health Service Providers

Generally, RHAs have broader and more extensive corporate powers than LHINs. For example, many RHAs can exercise the following powers that LHINs do not have:

- Provision of health-care services
- Ordering the closure or amalgamation of organizations (the LHIN may only do so in the context of a voluntary integration by HSPs);
- Purchasing, leasing or otherwise acquiring property, including hospital property and actual hospitals;
- Borrowing money and pledging assets as security;
- Directly accepting donations, grants and gifts;
- Creating Foundations (and potentially replacing the role of existing foundations);
- Winding-up Foundations; and
- Transferring donated funds from hospital foundations to RHAs for the benefit of the region.

Retention of Health Service Provider Independent Governance

Unlike other RHA models, LHINs are not explicitly empowered to order the consolidation of existing health organizations' governance structures. Therefore, health-care providers such as hospitals, long term care homes, and community health centres maintain their independent local boards of directors.

Many RHAs assumed some of the functions formerly performed by hospital boards. For example, in British Columbia, hospital boards – previously constituted as boards under the *Society Act* – were disbanded following regionalization. While hospitals continued to maintain important statutory and other responsibilities (i.e., under the *Hospital Act*), they were exercised primarily through various hospital committees (e.g., the Medical Advisory Committee).

LHIN-RHA Differences

Some important differences between LHINs and RHAs are:

1. **LHINs do not provide health-care services**
2. **LHINs have a different role and consequently fewer powers to integrate the system (e.g., cannot order provider closures) and must provide proposed integration decisions to health-care providers (HSPs) and the public**
3. **Local governance structures (e.g., hospital and long-term care home boards of directors) remain in place in Ontario**
4. **LHINs must consult with the local communities about health-care planning and priorities**

Mandatory Community Consultation

LHINs are significantly different from many RHA models in that LHINs are required to consult with their communities for planning purposes. LHINs must also provide a notice of a proposed integration decision to a HSP subject to the decision, and make the proposed decision available to the public. Many RHA provinces do not require the RHA to consult with health-care providers or local communities, even prior to such significant decisions as facility closures or service transfers.

Provincial Health Services Authorities

The Ontario LHIN structure is similar to other provincial health-care regionalization models in that the Ministry has retained responsibility for certain provincial programs, as is the case for the provincial governments in RHA systems. For example, most provinces maintain central responsibility for the provincial health insurance plan and for the province's drug benefits program.

However, unlike Ontario, some provinces have created distinct structures to manage and govern provincial health-care programs and services. For example, when British Columbia reconfigured its regionalization model in 2001, the province created a Provincial Health Services Authority ("PHSA") to coordinate and deliver provincial programs and highly specialized services that cannot be offered in all regions. The PHSA includes facilities and programs delivered by the BC Cancer Agency, the BC Transplant Society, the BC Centre for Disease Control, Children's and Women's Health Centre, Review Hospital and the Forensic Psychiatric Institute Program. It is possible that, over time, Ontario may also decide to create similar provincial authorities to manage provincial programs and services.

In addition to administering provincial programs, there is also a need to coordinate health services from the provincial perspective. Although there is no requirement under LHSIA for LHINs to coordinate services provincially, the objects for LHINs set out in LHSIA do refer to the provincial interest; for example, LHINs are to co-operate with HSPs and other LHINs to improve the integration of provincial health systems and LHINs and HSPs must jointly identify opportunities to integrate the services of local health systems to provide appropriate, co-ordinated, effective and efficient services (i.e., see section 24 of LHSIA). LHINs are also to participate in joint strategies with other LHINs to improve access and continuity of care across the province. One of the challenges for LHINs will be to coordinate services among themselves in the provincial interest.

LHIN POWERS AND POLICY IMPACT

LHINs have just begun to assume their full mandates with the transfer of funding from the Ministry to LHINs in April 2007. It is far too soon to assess the impact of the creation of LHINs in Ontario. However, with the creation of LHINs one can note a number of significant policy changes in health-care management and governance, as well as untested areas or areas of uncertainty in terms of the exact scope of LHIN powers.

Uncertainty about LHIN Powers

LHINs have yet to exercise the full range of their legislated powers. Therefore understanding the full scope of LHIN powers through implementation is not yet possible. However, based on an interpretation of LHSIA and the LHIN accountability agreements with hospitals and the Ministry, some considerations relating to the scope and extent of LHIN powers are as follows:

Evolution of LHIN Powers

There are broad regulation making authorities under the LHSIA which means that over time, the government may, through regulations issued by the Lieutenant Governor in Council, change the powers and responsibilities of LHINs. This could either increase or decrease the scope of LHIN powers and jurisdiction.

In addition, LHSIA permits the devolution by regulation to a LHIN of many powers or functions of the Minister under any statute for which the Minister is responsible. This means that the LHINs could fulfill the Minister's role under various statutes relating to health-care.

Another LHSIA provision relating to the potential growth of LHIN powers or jurisdiction is the ability of the Minister to assign to a LHIN the Minister's rights under an agreement with a HSP. However, a LHIN cannot assume Ministry rights and obligations from agreements that relate to the remuneration of certain health professionals on a basis other than fee for service; for example, hospital agreements with physicians for Alternative Funding Agreements or On-Call Coverage Programs.

In summary, LHSIA gives the government the ability to significantly increase the powers and jurisdiction of LHINs over time. It is not known whether the Ministry will devolve additional responsibilities to LHINs that impact the scope of their powers and responsibilities.

Extent of Autonomy from Minister

Under LHSIA and the MLAA, the Minister exerts considerable control over the LHINs. There is no clear indication yet about the extent of autonomy the LHINs will have from the Minister and Ministry in performing their role. The extent of Ministerial oversight relates to the LHIN corporate context; for example, the degree of Ministerial involvement in LHIN operational procedures, and governance practices and processes. It also relates to LHIN decisions about health-care, for example potential Ministerial involvement in LHIN funding and integration decisions.

In turn, it is unknown how extensively the Minister will consult with LHINs before setting priorities or embarking on major health-care initiatives that impact local health-care systems.

Scope and Impact of Integration Powers

LHINs have begun to use integration powers already. However, it is difficult to fully understand the scope and impact of these powers. For example, integration decisions could significantly impact a health service provider's ability to operate such that one might argue the LHIN is acting beyond its jurisdiction (albeit unintentionally) by effectively closing the provider's operations.

The mechanics of implementing integration decisions aren't apparent; for example, how will funding decisions related to the integration of services be determined? What will be the impact of integration decisions on a provider's overall ability to provide its services and meet its service accountability agreement obligations? How will the transfer of property (including privately donated funds) related to the integrated services be handled? Further, will the LHIN or health service provider have the responsibility for the costs associated with a transfer of services (e.g., obtaining patient consent for the transfer of personal health information)? One can also anticipate a number of

governance and legal arguments that may be advanced by powerful boards and community stakeholders in reaction to LHIN integration decisions.

Primary Care Reform and Physician Issues

While LHINs have the authority to plan services for their local health regions, it remains unclear how effective this authority will be given the exclusion of physician services and primary care (e.g., Family Health Teams) from their jurisdiction (i.e., it remains with the Ministry). While the Ministry and LHINs may coordinate their health-care planning priorities in these areas, it is unclear whether the lack of LHIN authority for these areas will impact LHIN effectiveness to fulfill their mandate and the policy objectives in creating LHINs. Physicians have been engaged on Health Professions Advisory Committees. However, it is unclear whether this mechanism or others will be successful in engaging physicians in the fulfillment of LHIN mandates and local community planning.

Policy Impact

Local Health-Care Governance

The Ministry has devolved to LHINs significant powers and responsibilities that result in a transfer of provincial planning and governance functions for major health-care providers and communities. This results in the most apparent policy shift in the creation of LHINs - the affirmation of local health-care planning and management for the delivery of effective and efficient health-care services. Obviously it is too early to assess whether the creation of LHINs fulfils this policy premise.

Provincial Planning

The affirmation of local health system management and governance for LHIN health-care providers coincides with the apparent diminution of transparent and coordinated health-care planning, management and accountability of those health service providers governed by LHINs. There is no requirement for LHINs to consult or communicate with each other in their planning, integration and funding responsibilities. Similarly, there is no requirement that SAAs be developed, negotiated or enforced in a consistent manner across LHINs. LHIN levels and scope of community engagement need not be coordinated or consistent. There is, however, nothing preventing them from working together or coordinating on issues of common cause.

Arguably, the policy of promoting local health system governance may result in a decrease of provincially coordinated health-care planning for and delivery of LHIN governed services. However, as the LHINs have only relatively recently begun to implement their full mandates, one may yet see the creation of LHIN structures to facilitate coordinated and consistent LHIN planning and governance.

Provincial Programs

The fact that the Ministry has retained management of a number of significant provincial programs indicates a recognition that local health-care system governance should not be extended to all health-care providers and services. This applies to such provincial programs and operations as Cancer Care Ontario, drug plans and organ donation.

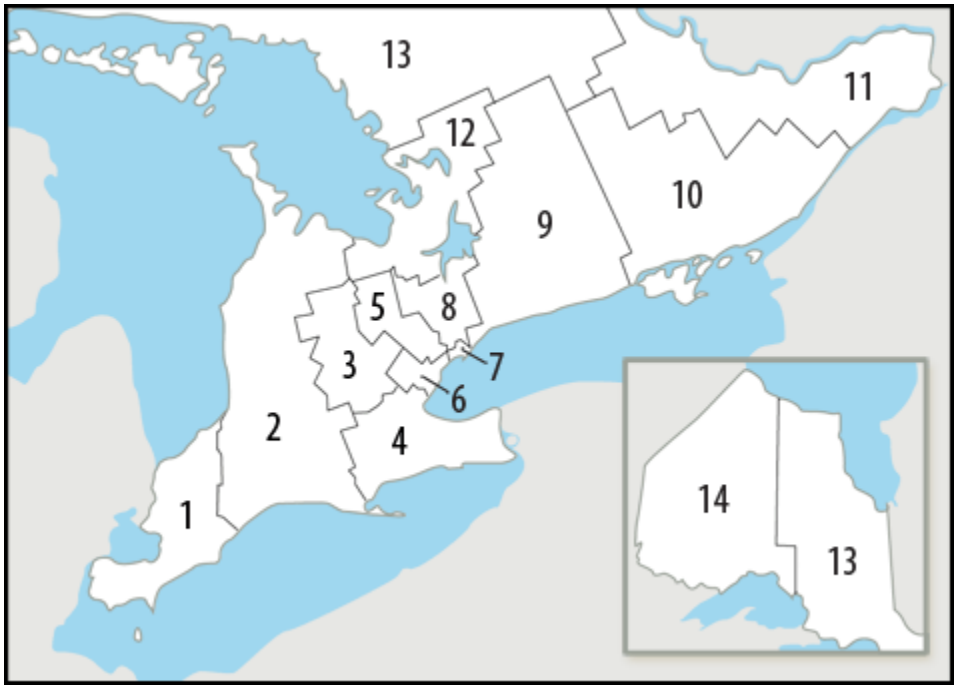
Affirmation of Health Service Provider Independent Governance

Unlike the regionalization reforms in other provinces, Ontario did not empower LHINs to consolidate or remove the boards of directors of health-care service providers. Such a limitation on LHIN authority indicates support for independent local board governance for the management and delivery of health-care services.

APPENDIX A

Ontario's Local Health Integration Networks

1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West



APPENDIX B

Volumes and Indicators for the H-SAA

Service Volumes

- Total Acute Activity Including Inpatient & Day Surgery Weighted Case
- Elderly Capital Assistance Program Inpatient Days
- Complex Continuing Care Resource Utilization Group Weighted Patient Days
- Emergency Department Visits
- Mental Health Inpatient Days
- Rehabilitation Inpatient Days
- Ambulatory Care Visits

Indicators

- Readmissions to Own Facility for Selected CMGs
- Current Ratio (balance budget requirements)
- Percentage of Full Time Nurses
- Percentage of Chronic Patients with New Stage 2 or Greater Skin Ulcers (Chronic Care Designated Activity only)
- Total Margin (balance budget requirements)

Performance Obligations for Specific Funding

- Critical Care Beds and Services
- Post Construction Operating Plan Funding
- Protected Services (as defined in the H-SAA Schedules)
- Wait Time Services